MEDICAL COVERAGE POLICIES
EXTRACTED FROM 10A NCAC 22O

HOSPITAL INPATIENT

(a) Prior approval shall be required for surgical transplants except bone and tendon.
(b) Private rooms shall be reimbursed only when medically necessary (or when a census makes it necessary). Claims must be supported by a physician's statement.
(c) Medical necessity for acute hospital level-of-care and length of stay will initially be determined by a hospital's Utilization Review Committee; however this need will be subject to post-payment review by the state agency. All claims will be subject to prepayment review for Medicaid coverage.

HOSPITAL OUTPATIENT

(a) Prior approval shall be required for each psychiatric hospital outpatient visit after the first eight visits for recipients age 21 and over or 26 visits for recipients under age 21.
(b) Routine physical examinations shall be covered as a hospital outpatient service in accordance with established criteria.
(c) Injections shall not be covered when oral drugs may be used in lieu of injections.
(d) Take-home legend drugs shall not be provided, except when needed by the patient until such time as the patient can obtain a continuous supply.

HOME HEALTH SERVICES

Home health services shall be provided by Medicare certified home health agencies under a plan of care authorized by the patient's physician.
(a) Covered home health services include nursing services, services of home health aides, speech therapy, physical therapy, occupational therapy, medical supplies, equipment and appliances.
(b) A plan of care which is signed by the physician and which details the services to be provided must be on file.
(c) Services of a home health aide for provision of personal care shall not be covered as a home health service except when provided under appropriate professional supervision as part of care necessary to restore, rehabilitate or maintain health, including care for the terminally ill.

LABORATORY AND X-RAY SERVICES

Laboratory and x-ray services shall be covered to the extent permitted in federal Medicaid regulations and subject to the following conditions:

(1) Clinical laboratory services are rendered by medical care entities who are issued a certificate of waiver, registration certificate, or certificate of accreditation under the Clinical Laboratories Improvement Amendments of 1988.
(2) Portable x-ray services are medically necessary and ordered in writing by the attending physician. Services may be provided only by providers who are Medicare certified and inspected by the N.C. Division of Facility Services and are limited to provision in the patient's place of residence. The ordering physician must:
    (a) State the patient's diagnosis, and
    (b) Indicate the condition suspected, and
    (c) Reason why "portable" service is needed.
(3) Portable ultrasound services are medically necessary and ordered in writing by the attending physician. When provided by an Independent Diagnostic Testing Facility (IDTF), the provider must be Medicare certified as an IDTF; assure its personnel are licensed or registered in accordance with applicable State laws; have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, the qualifications of nonphysician personnel who use the equipment, and the level of supervision needed for the tests performed.

EYEGLASSES AND OPTOMETRIC SERVICES

(a) All visual aids require prior approval.

(b) No eyeglass frames other than frames made of zylonite, metal, or combination zylonite and metal shall be covered.

(c) Eyeglass repair or replacement, or any other service costing five dollars ($5.00) or less, shall not be covered.

(d) Prior approval shall be required for more than one refraction per year for any person up to age 25; more than one refraction every two years for any person aged 25 and over; and all repairs and replacement of frames and lenses exceeding a cost of five dollars ($5.00).

CHIROPRACTIC SERVICES

(a) Medicaid coverage of chiropractic services is limited to manual manipulation of the spine to correct a subluxation.

(b) No reimbursement shall be made for x-rays or other diagnostic or therapeutic services provided by a chiropractor except for one x-ray to document the neuromusculoskeletal condition for which manual manipulation of the spine is appropriate.

MENTAL HEALTH CENTER SERVICES

(a) Psychiatric testing at a mental health center shall be covered only when the center has individualized treatment plans and goals for the patient. Payment shall be made only if the testing is medically necessary.

(b) Mental health centers providing active treatment for psychiatric or medical illness occurring in the mentally retarded shall be covered for such treatment.

(c) There must be a current diagnosis, treatment plan, and specific goals for each patient. The visit must be medically necessary.

INTERMEDIATE CARE FACILITIES

(a) Prior approval for services in intermediate care facilities shall be required for all new admissions.

(b) Utilization review in each facility shall be provided through personnel under contract.

(c) With respect to intermediate care facilities, prior approval shall be required for all Utilization Review Committee recommendations that require a change in the level of care; however, these recommendations will be taken into consideration at the time of review.

(d) Prior approval shall be required for intermediate care facility patients seeking Title XIX assistance who were previously private pay or insured by a third party carrier.

(e) Prior approval shall be required when a patient is discharged from an intermediate care facility to a lower level of care or to his own home, and later returns to a level of care that requires prior approval.

(f) Prior approval shall be required when an intermediate care facility Medicaid patient's benefits are terminated for 90 days or more before reinstatement, even though the patient remains in the same facility.

(g) Prior approval shall not be required for an intermediate care facility patient who is hospitalized and returns to the previously approved level of care.

(h) Prior approval shall not be required for an approved intermediate care facility patient who leaves the facility for an overnight stay, provided the absence is authorized by the attending physician.

(i) Prior approval shall not be required when the Utilization Review contractor recommends a change in the level of care. These recommendations shall be accepted.

(j) The form approved for intermediate care facility placement shall be valid for 60 days. This form shall be filed by the team, and shall certify that the person is entitled to care for a specified period. The form shall state the medical problem involved.

HEARING AID SERVICES

Only hearing aids and accessories provided to recipients under age 21 shall be covered. Prior approval shall be required for hearing aid and accessories, ear molds, repairs, loaner and rental aids.

AMBULANCE SERVICES

(a) Reimbursement for ambulance services shall be made only for transportation to the nearest appropriate facility (hospital, nursing home, or intermediate care facility), doctor's office or clinic that provides medical services.

(b) Services provided by an ambulance provider under the Medicaid program must be demonstrated to be medically necessary and are subject to limitations described herein. Medical necessity is indicated when the patient's condition is such that any other means of transportation would endanger the patient's health. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely utilized.

(c) Emergency ambulance transportation is for the client to receive immediate and prompt medical services arising in an emergency situation. Emergency transportation to a physicians' office is covered only if all the following conditions are met:

(1) The patient is enroute to a hospital.

(2) There is medical need for a professional to stabilize the patient's condition.

(3) The ambulance continues the trip to the hospital immediately after stabilization.

(d) Non-emergency ambulance transportation to and from a physician directed office, clinic, or other medical facility in which the individual is an inpatient is covered in the following situation:

(1) Medical necessity is indicated when the use of other means of transportation is medically contraindicated because it would endanger the patient's health. This refers to clients who require transport by stretcher.

(2) Client is in need of medical services that cannot be provided in the place of residence.

(3) Return transportation from a facility which has capability of providing total care for every aspect of injury or disease to a facility which has fewer resources to offer highly specialized care.

(e) In order to claim Medicaid reimbursement, providers of ambulance services must be able to document that ambulance services were medically necessary.

(1) The codes billed on the UB-92 claim form must be supported by documentation on the call report.

(2) A legible copy of the ambulance call report to support medical necessity and the codes billed on the UB-92 claim form must be kept on file by the provider for five years which indicates:

(A) the purpose for transport,

(B) the treatments,

(C) the patient's response, and

(D) the patient's condition that sufficiently justifies transport by stretcher was medically necessary.

(f) Prior approval is required for non-emergency transportation for recipients to receive out-of-state services or to return to North Carolina or nearest appropriate facility.

INPATIENT PSYCHIATRIC HOSPITAL SERVICES

Inpatient psychiatric hospital services are covered in private psychiatric hospitals for services provided in beds licensed as inpatient psychiatric or substance abuse hospital beds and in State mental hospitals, for recipients under age 21, for recipients defined in 42 CFR 441.151 (c), and for recipients over age 65 as defined in Social Security Act 1905 (a) and (h) and 1861 (f). The admitting hospital is responsible for obtaining certification for person under age 21 in accordance with Subpart D of 42 CFR 441. Admission to all out of state psychiatric hospitals including those enrolled as border psychiatric hospitals are subject to prior approval for necessity to go out of state. Admissions to psychiatric hospitals enrolled as border hospitals are limited to cases where it is the general practice for recipients in a particular locality to use medical resources in the other State. Services in out of state hospitals are provided only to the same extent and under the same conditions as medical services provided in North Carolina.

PSYCHIATRIC ADMISSION CRITERIA/MEDICAID BENEFICIARIES UNDER AGE 21

Medicaid criteria for the admission of those persons under age 21 to psychiatric hospitals or psychiatric units of general hospitals is limited herein. To be approved for admission, the patient must meet criteria in Items (1), (2) and (3) of this Rule as follows:

(1) Client meets criteria for one or more DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition -- a manual whose purpose is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders) diagnoses. This manual is hereby incorporated by reference including subsequent amendments and editions. Copies may be obtained from the American Psychiatric Association; and

(2) At least one of the following criteria:

(a) Client is presently a danger to self (e.g., engages in self-injurious behavior, has a significant suicide potential, or is acutely manic). This usually would be indicated by one of the following:

(i) Client has made a suicide attempt or serious gesture (e.g., overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on the threat, and there is an absence of supervision or structure to prevent suicide of the client who has made an attempt, serious gesture or threat.

(ii) Client manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide.

(iii) Client has a history of affective disorder:

(A) with mood which has fluctuated to the manic phase, or

(B) has destabilized due to stressors or non-compliance with treatment.

(iv) Client is exhibiting self-injurious behavior (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or

(b) Client engages in actively violent, aggressive or disruptive behavior or client exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others. This usually would be indicated by one of the following:

(i) Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, severe oppositionalism, running away, severely disruptive behaviors at home or school, self-defeating and self-endangering activities, antisocial activity, and other behaviors which may occur in the context of a dysfunctional family and may also include physical, psychological, or sexual abuse.

(ii) Client exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals) or is threatening same with likelihood of acting on the threat. This behavior should be attributable to the client's specific DSM-IV diagnosis and can be treated only in a hospital setting; or

(c) Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the client unmanageable and unable to cooperate in treatment. This usually would be indicated by the following: Client has recent onset or aggravated psychotic symptoms (e.g., disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speech, severely impaired judgment) and is resisting treatment or is in need of assessment in a safe and therapeutic setting; or

(d) Presence of medication needs, or a medical process or condition which is life-threatening (e.g., toxic drug level) or which requires the acute care setting for its treatment. This usually would be indicated by one of the following:

(i) Proposed treatments require close medical observation and monitoring to include, but not limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems.

(ii) Client has a severe eating disorder or substance abuse disorder which requires 24-hour-a-day medical observation, supervision, and intervention.

(iii) Client has Axis I or Axis II diagnosis, with a complicating or interacting Axis III diagnosis, the combination of which requires psychiatric hospitalization in keeping with any one of these criteria, and with the Axis III diagnosis treatable in a psychiatric setting (e.g., diabetes, malignancy, cystic fibrosis); or

(e) Need for medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication. This usually would be indicated by one of the following:

(i) Client whose diagnosis and clinical picture is unclear and who requires 24 hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.

(ii) Client is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; and

(3) To meet the federal requirement at 42 CFR 441. 152, all of the following must apply:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.

(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

(c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

NC MEDICAID CRITERIA FOR CONTINUED ACUTE STAY IN AN INPATIENT PSYCHIATRIC FACILITY

The following criteria apply to individuals under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital. These criteria shall be applied after the initial admission period of up to three days. To qualify for Medicaid coverage for a continuation of an acute stay in an inpatient psychiatric facility a patient must meet each of the conditions specified in Items (1) through (4) of this Rule. To qualify for Medicaid coverage for continued post-acute stay in an inpatient psychiatric facility a patient must meet all of the conditions specified in Item (5) of this Rule.

(1) The patient has one of the following:

(a) A current DSM-IV, Axis I diagnosis; or

(b) A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:

(i) Symptoms/behaviors are likely to respond positively to acute inpatient treatment; and

(ii) Symptoms/behaviors are not characteristic of patient's baseline functioning; and

(iii) Presenting problems are an acute exacerbation of dysfunctional behavior patterns which are recurring and resistive to change.

(2) Symptoms are not due solely to mental retardation.

(3) The symptoms of the patient are characterized by:

(a) At least one of the following:

(i) Endangerment of self or others; or

(ii) Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out hair); or

(iii) Related to repetitive behavior disorders which present at least five times in a 24-hour period; or

(iv) Directly result in an inability to maintain age appropriate roles; and

(b) The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.

(4) The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

(5) In the event that not all of the requirements specified in Items (1) through (4) of this Rule are met, reimbursement may be provided for patients through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at a pre-determined residential rate if the facility and program services are appropriate for the patient's treatment needs and provided that all of the following conditions are met:

(a) The psychiatric facility has made a referral for case management and after care services to the area Mental Health, Developmental Disabilities, Substance Abuse (MH/DD/SA) program or Local Management Entity (LME) which serves the patient's county of eligibility.

(b) The area MH/DD/SA program or LME has found that no appropriate services exist or are accessible within a clinically acceptable waiting time to treat the patient in a community setting.

(c) The area MH/DD/SA program or LME has agreed that the patient has a history of sudden decompensation or measurable regression and experiences weakness in his or her environmental support system which is likely to trigger a decompensation or regression. This history must be documented by the patient's attending physician.

(d) These services can only be provided if community placement is not available at the discharge date and both the hospital and area MH/DD/SA program or LME are actively working on discharge planning. This service requires prior approval from the entity designated by the Division of Medical Assistance.

(e) The entity designated by the Division of Medical Assistance shall approve the use of extended treatment based on criteria in Sub-items (a)-(d) of this Item.

(f) Claims should be submitted on a UB-92 form (hospital outpatient claim type M) using Revenue Center code 902, procedure code Y2343 and bill type 141. Only physician visits and case management may be billed in addition to procedure code Y2343. Effective July 1, 2002, hospitals providing services as outlined in item (5) of this Rule must submit claims for reimbursement to Medicaid's fiscal agent.

CLINIC SERVICES

(a) Clinic services for which the physician or dentist files directly for payment shall not be covered.
(b) Clinic services specifically covered in other Title XIX programs shall not be covered.
(c) Clinic services provided at hospital clinics or at volunteer clinics not affiliated with the county health department shall not be covered, regardless of the amount of assistance provided by the county health department.
(d) Only clinic services furnished by or under the direction of a physician or dentist shall be covered.

SKILLED NURSING FACILITY SERVICES

(a) Private accommodations shall not be covered, except when directed by a physician on the basis of medical necessity or when a patient census precludes semi-private assignment.
(b) Prior approval for services in skilled nursing facilities shall be required for all admissions. Where cases warrant expeditious action, telephonic approval can be obtained.
(c) Utilization review in each skilled nursing facility shall be provided by personnel under contract.
(d) Participation (enrollment) as a Medicare provider is a prerequisite to participation (enrollment) in the North Carolina Medicaid Program. North Carolina Medicaid is payer of last resort; facilities participating in North Carolina Medicaid must bill Medicare for all eligible clients prior to billing Medicaid. All Medicare coverage, for services provided, must be exhausted prior to billing Medicaid.

ABORTION

Lawful abortions shall be covered under Medicaid in accordance with federal law.

PHARMACY SERVICES

(a) A prescription for a drug designated by a brand or trade name shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicates on the prescription order "medically necessary."
(b) Coverage of prescribed drugs will be limited to legend drugs and insulin, except those designated by the Food and Drug Administration as not having been shown to be effective. Co-payment must be collected from the recipient on all prescriptions dispensed, including refills. Pharmacists participating in the Medicaid program shall substitute the least expensive generic drugs in stock for brand or trade name drugs in the absence of a prescription specifically to the contrary.
(c) The pharmacy of choice is that pharmacy selected by a recipient and who, at the time of payment holds the pharmacy stub from his Medicaid identification card. The Division of Medical Assistance will guarantee payment, up to the state's statutory limit, for drugs for eligible recipients in any month only to the pharmacy of choice.
(d) The recipient may change his pharmacy of choice at any time. A recipient may change his pharmacy by finding a pharmacy which participates in the North Carolina Medicaid Program which is willing to accept him as a client. The new pharmacist may coordinate with the previous pharmacy of choice. Coordination between the pharmacies may be necessary to:

(1) assure the well being of the client by discouraging shopping;
(2) assure the newly chosen pharmacist that the recipient has not reached or exceeded any statutory prescription limit.

(e) No pharmacist is required to accept a new client. Pharmacists accept new clients by their own choice.

(f) Recipients identified by 10A NCAC 22F .0704, Recipient Management Lock-In System, must comply with that Rule.

OUT-OF-STATE SERVICES

(a) Reimbursement shall be made to providers outside of North Carolina in the case of an emergency, or if travel back to the state would endanger the health of the eligible recipient.

(b) Prior approval is required for non-emergency out-of-state services more than 40 miles outside North Carolina's border.

PERSONAL CARE SERVICES

(a) The Division of Medical Assistance will cover personal care services in accordance with federal law. The provision of personal care services must be physician authorized and must meet the following criteria:

(1) The recipient of the service must have a medical diagnosis that warrants a physician's care and that recipient must be under the direct and ongoing care of the physician prescribing PCS.
(2) The recipient's medical condition must be stable at maintenance level.
(3) There must be a medical necessity for the provision of personal care services.

(b) An enrolled provider must be a State licensed home care agency located within North Carolina that is approved in its license to provide in-home aide services.

(c) Reimbursement is not available for personal care services exceeding three hours 30 minutes per recipient per calendar day and 60 hours per recipient per calendar month.

(d) Reimbursement for personal care services is not available to a given recipient on the same day another substantially equivalent service is provided. Substantially equivalent services include home health aide services, and personal care services provided through In-home Aide services at Level II and Level III - Personal Care as defined in 10 NCAC 22J .0103(2) and 10 NCAC 22J .0103(4).

(e) A member of the recipient's immediate family may not be employed by a provider agency to provide personal care services reimbursed by Medicaid. Immediate family members are defined as spouses, children, parents, grandparents, grandchildren, siblings, including corresponding step- and in-law relationships.

DURABLE MEDICAL EQUIPMENT

(a) Medically necessary durable medical equipment (DME) is covered by the Medicaid program when it is prescribed by an appropriate health care professional as designated by established medical policy. Prior approval must be obtained from the Division of Medical Assistance, or its designated agent when required by established medical policy.

(b) Payment for durable medical equipment is limited to the official, approved DME and Orthotic and Prosthetic lists established by the Division of Medical Assistance. Additions, deletions or revisions to the DME and Orthotic and Prosthetic lists are approved by the Director of the Division of Medical Assistance upon recommendation of DMA staff and consultants. Only items determined to be medically necessary, effective and efficient may be included.

(c) Providers must meet the following conditions to qualify for participation in the Medicaid Program:

(1) Not accept prescriptions for Medicaid covered equipment from any physician or practitioner who has an ownership interest in the provider's DME business, and
(2) Be enrolled and participate in Medicare as a DME supplier, and
(3) Provide services on an emergency basis 24 hours per day, seven days per week for life sustaining equipment, and
(4) Be located within the boundaries of NC or in an adjoining state from whom NC recipients living on the border use the provider as a general practice, and
(5) Be either:
    (A) A business entity authorized to conduct business in the state or in the locality where the business site is located. Proof of authorization shall include a certificate of assumed name, certificate of authority, certificate of good standing, license, permit, or privilege license, or
    (B) A Medicaid enrolled home health agency, a state agency, a local health department, a local lead agency for the Community Alternatives Program for Disabled Adults, or mentally retarded or developmentally disabled, or an agency that provides case management for the Community Alternative Program for children.

PRIVATE DUTY NURSING

(a) Medically necessary private duty nursing (PDN) services are provided when they are prescribed by a physician and prior approved by the Division of Medical Assistance or its designee.

(b) A patient must reside in the patient's private residence to receive PDN services. Recipients who are in domiciliary care facilities (such as rest homes, group homes, family care homes, and similar settings) and those who are in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

(c) Private duty nursing services are considered medically necessary when the person must require substantial and complex continuous nursing care by a licensed nurse. Professional judgment and a thorough evaluation of the medical complexity and psychosocial needs of the patient are involved in determining the need for PDN. The following situations represent the usual types of cases that may require PDN, though the list is not meant to be all-inclusive:

(1) Patient requires prolonged intravenous nutrition or drug therapy with needs beyond those covered by home infusion therapy services.
(2) Patient is dependent on a ventilator for prolonged periods.
(3) Patient is dependent on other device-based respiratory support, including tracheostomy care, suctioning, and oxygen support.

(d) This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

(e) A person may not receive Personal Care Services, Skilled Nursing Visits, and Home Health Aide Services reimbursed by Medicaid during the same hours of the day as PDN services.

(f) The patient's spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship may not be employed by the provider agency when reimbursed by Medicaid to provide PDN services to the patient.

(g) Medicaid payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency located within North Carolina that is approved in its license to provide nursing services.

CASE MGMT SVCS/ADULTS/CHILDREN AT-RISK/ABUSE/ NEGLECT/ EXPLOITATION

(a) Case management is a set of interrelated activities under which responsibility for locating, coordinating and monitoring appropriate services for an individual rests with a specific person or organization. The purpose of case management services for adults and children at-risk of abuse, neglect, or exploitation is to assist them in gaining access to needed medical, social, educational, and other services; to encourage the use of cost-effective medical care by referrals to appropriate providers; and to discourage over-utilization of costly services. Case management services will provide necessary coordination with providers of non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which he or she is eligible. The set of interrelated activities are as follows:

(1) Evaluation of the client's individual situation to determine the extent of or need for initial or continuing case management services.
(2) Needs assessment and reassessment to identify the service needs of the client.
(3) Development and implementation of an individualized plan of care to meet the service needs of the client.
(4) Providing assistance to the client in locating and referring him or her to providers or programs that can meet the service needs.
(5) Coordinating delivery of services when multiple providers or programs are involved in care provision.
(6) Monitoring and following-up to ensure services are received, adequate to meet the client's needs, and consistent with good quality of care.

(b) The target group includes:

(1) Adults who are at-risk or show evidence of abuse, neglect, or exploitation as defined in G.S. 108A-101. Children who are at-risk or show evidence of abuse or neglect as defined in G.S. 7B-101; and
(2) Who are Medicaid recipients; and
(3) Who are not institutionalized; and

(4) Who are not recipients of other Medicaid-reimbursed case management services provided through the State's home and community-based services waivers or the State Plan; and

(5) Who reside in counties providing the non-Federal matching funds to offer this service.

(c) The case manager shall determine whether an adult or child is at-risk of abuse, neglect, or exploitation as follows:

(1) At-Risk Adult: An at-risk adult is an individual who is at least 18 years old, or an emancipated minor, and meets one or more of the following criteria:

(A) An individual with only one consistent identified caregiver, who needs personal assistance 24 hours per day with two or more of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or

(B) An individual with no consistent identified caregiver, who is unable to perform at least one of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or

(C) An individual with no consistent identified caregiver, who is unable to carry out instrumental activities of daily living (managing financial affairs shopping, housekeeping, laundry, meal preparation, using transportation, using a telephone, reading, writing); or

(D) An individual who was previously abused, neglected or exploited, and the conditions leading to the previous incident continue to exist; or

(E) An individual who is being abused, neglected, or exploited and is in need of protection.

(2) At-Risk Child: An at-risk child is an individual under 18 years of age who meets one or more of the following criteria:

(A) A child with a chronic or severe physical or mental condition whose parent(s) or caretaker(s) are unable or unwilling to meet the child's care needs;

(B) A child whose parents are mentally or physically impaired to the extent that there is a need for assistance with maintaining family stability and preventing or remedying problems which may result in abuse or neglect of the child; or

(C) A child of adolescent (under age 18) parents or parents who had their first child when either parent was an adolescent and there is a need for assistance with maintaining family stability, strengthening individual support systems, and preventing or remedying problems which may result in abuse or neglect of the child; or

(D) A child who was previously abused or neglected, and the conditions leading to the previous incident continue to exist; or

(E) A child who is being abused or neglected and is in need of protection.

(d) Enrollment of providers shall be accomplished in accordance with section 1902(a) (23) of the Social Security Act.

(1) Case Manager Qualifications. Case managers must meet the following qualifications:

(A) A case manager for at-risk adults must:

(i) Have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification; and

(ii) Have training in recognizing risk factors related to abuse, neglect, or exploitation of elderly or disabled adults and in assessment of functional capacity and needs related to activities of daily living; and

(iii) Have experience in case management services for elderly and disabled adults.

(B) A case manager for at-risk children must:

(i) Have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification; and

(ii) Have training in recognizing risk factors related to abuse or neglect of children and in assessing family functioning; and

(iii) Have experience in case management services for children and their families.

(2) Provider Qualifications. Providers must meet the following qualifications:

(A) Meet applicable State and Federal laws governing the participation of providers in the Medicaid program.

(B) Be certified by the Division of Social Services as a qualified case management provider. To be certified, a provider must:

(i) Have qualified case managers with supervision provided by a supervisor who meets State requirements for Social Work Supervisor I or Social Work Supervisor II classification.

(ii) Have the capability to access multi-disciplinary staff, when needed. For adults this includes, at a minimum, medical professionals as needed and an adult protective services social worker meeting the qualifications in Subparagraphs (d)(1)(A)(i) and (d)(1)(A)(ii) of this Rule. For children, this must include medical professionals as needed and a child protective services social worker meeting the qualifications in Subparagraphs (d)(1)(B)(i) and (d)(1)(B)(ii) of this Rule.

(iii) Have experience as a legal guardian of persons and property.

HIV CASE MANAGEMENT

(a) The components of HIV case management are listed below. In order to be reimbursed by the Division of Medical Assistance, a provider shall provide all of these components:

(1) Evaluation of the client's situation to determine the need for initial case management services;

(2) Comprehensive assessment of the client's health care, psychosocial, environmental and financial needs;

(3) Development and implementation of a plan of care which includes goals, services to be provided and progress notes;

(4) Coordination of service delivery when multiple providers or programs are involved in care provision;

(5) Monitoring to ensure that services received meet the client's needs and are consistent with good quality of care;

(6) Follow-up and assessment to determine the continued appropriateness of services, the correct level of care, and the continued need for services;

(7) Discharge of the client from service; and

(8) Locating and helping access available systems, resources and services within the community to meet the client's needs.

(b) Persons are eligible to receive HIV case management services if they:

(1) Have a medical diagnosis of HIV disease or HIV seropositivity; and

(2) Are eligible for regular Medicaid services; and

(3) Are not institutionalized; and

(4) Are not recipients of other Medicaid-reimbursed case management services provided through the State's home and community-based waivers or the State Plan.

(c) Provider Qualifications. Providers of HIV case management services shall:

(1) Be enrolled in accordance with section 1902(a)(23) of the Social Security Act; and

(2) Meet applicable State and Federal Laws governing the participation of providers in the Medicaid program; and

(3) Be certified by the Division of Public Health, Department of Health and Human Services as a qualified HIV case management provider. To be certified, a provider must:

(A) Submit an application to the Division of Public Health that includes the provider's plans for:

(i) Provision of all the HIV case management components in (a); and

(ii) Quality assurance, including the monitoring and evaluation of case management records.

(B) Have qualified case managers with supervision provided by a supervisor who meets the requirements in (d), except that case managers qualified under (e)(4) shall have all their charts reviewed and signed by such a supervisor.

(d) Supervisor Qualifications. An HIV case management supervisor shall meet the following qualifications:

(1) Have a master's level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and one year of experience in case management; or

(2) Have a bachelor's level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and two years experience in case management; or

(3) Have graduated from an accredited school of professional nursing and completed three years of professional nursing experience, including two years in Public Health. Be licensed to practice as a registered nurse and have a minimum of two years experience in case management; or

(4) Have graduated from an accredited school of professional nursing and completed three years of professional nursing experience, including two years experience supervising nurses responsible for developing and maintaining care plans and coordinating care and services for patients receiving care in their homes. Be licensed to practice as a registered nurse and have a minimum of two years experience in case management.

(e) Case Manager Qualifications. HIV case managers shall meet the following qualifications:

(1) Have a master's level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing; or

(2) Have a bachelor's level degree in a human service area including, but not limited to, Social Work, Sociology, Child Development, Maternal and Child Health, Counseling, Psychology or Nursing and two years experience working in human services; or

(3) Be a licensed Registered Nurse, Nurse Practitioner, Physician Assistant or Certified Substance Abuse Counselor with two years experience working in human services; or

(4) Have a high school diploma and two years experience providing HIV case management. A person who qualifies under (e)(4) may serve as an HIV case manager for five years from date of employment as an HIV case manager in an agency certified to provide HIV case management. If an agency is not a certified HIV case management provider at the time of the person's employment as an HIV case manager, the five-year time period begins with the agency's certification date. After the five year period ends, the person must meet HIV case manager requirements defined in (e)(1), (2), or (3) in order to continue providing HIV case management services; and

(5) Attend, at least annually, training sessions approved by the Division of Public Health, Department of Health and Human Services.

HOME INFUSION THERAPY

(a) Self-administered Home Infusion Therapy (HIT) is covered when it is medically necessary and provided through an enrolled HIT agency as prescribed by a physician. "Self-administered" means that the patient or an unpaid primary caregiver is capable, able, and willing to administer the therapy following teaching and with monitoring. The following therapies are included in this coverage when self-administered:

(1) Total parenteral nutrition;

(2) Enteral nutrition;

(3) Intrathecal and intravenous chemotherapy;

(4) Intravenous antibiotic therapy;

(5) Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy.

(b) An agency must be a home care agency licensed in North Carolina for the provision of infusion nursing services to qualify for enrollment as a HIT provider.

In addition to enrolled HIT providers, agencies enrolled to provide durable medical equipment may provide the supplies, equipment, and nutrient formulae for enteral infusion therapy.

MEDICAL SERVICES

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

PHYSICIAN SERVICES

(a) Injections shall not be covered when oral drugs may be used in lieu of injections.

(b) A second opinion for surgery performed by a qualified practitioner is covered but not required. In all cases the final decision to perform the surgery rests with the recipient. A third opinion is covered but not required.

PODIATRIST SERVICES

Routine foot care including cutting or removal of corns and calluses, trimming, cutting, clipping, and debriding of nails and hygienic care is not covered. Exception: Routine foot care may be covered when:

(a) the services are medically necessary and are an integral part of otherwise covered services, (such as plantar warts); and/or

(b) there exists a systemic condition such as metabolic, neurologic, and/or peripheral vascular disease; and/or

(c) there is evidence of mycotic nails that, in the absence of a systemic condition, result in pain or secondary infection.

THERAPEUTIC LEAVE

(a) Each Medicaid eligible patient occupying a skilled nursing (SNF) or intermediate care (ICF or ICF-MR) bed shall be entitled to take therapeutic leave in accordance with G.S. 108-A-62.

(b) The taking of such leave must be for therapeutic purposes only, and must be ordered by the patient's attending physician. The necessity for such leave shall be documented in the patient's plan of care and therapeutic justification for each instance of such leave entered into the patient's medical record.

(c) Facilities must reserve a therapeutically absent patient's bed for him and are prohibited from deriving any Medicaid revenue for that patient other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.

(d) The therapeutic justification for such absence shall be subject to review by the state or its agent during scheduled on-site medical reviews.

(e) A patient's 12-month entitlement period shall begin on January 1 and continue through December 31 of a calendar year. Unused therapeutic leave days shall not be carried over from one calendar year to another.

(f) Facilities must keep a cumulative record of therapeutic leave days taken by each patient for reference and audit purposes. In addition, patients on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.

(g) The official record of therapeutic leave days taken for each patient shall be maintained by the state or its agent.

(h) Entitlement to therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving either inpatient or nursing services provided either elsewhere or at a different level of care in the facility of current residence when such services are or will be paid for by Medicaid.

(i) Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid.

DENTAL SERVICES

DEFINITIONS

(a) "Dental Services" means diagnostic, preventive or corrective procedures or dentures provided by or under the supervision of a dentist. These services include treatment of the teeth and associated structures of the oral cavity, and of disease, injury, or impairment which may affect the oral or general health of the individual.

(b) "Emergency dental care services" means those necessary to control bleeding, relieve pain, or eliminate acute infection, including emergency endodontic therapy; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; or treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth). Prosthetic repairs that, if delayed for prior approval, would adversely affect the health of the patient may be considered emergency procedures.

(c) "Routine services" means examinations, radiographs, preventive services, tooth extractions, minor oral surgical procedures, restorative services, prosthetic repairs and adjunctive services, such as general anesthesia, professional consultations and visits and the intramuscular injections of medicaments and drugs.

STANDARDS FOR PARTICIPATION

(a) Dentists who provide services under the Medicaid program are required to meet the following standards:

- (1) must be licensed by the appropriate state authority;
- (2) must provide services in accordance with the rules and regulations of the Medicaid program;
- (3) must agree that the State Medicaid Agency or its designated agents may audit Medicaid dental records as necessary;
- (4) must agree that payment received from Medicaid is accepted as payment in full for covered services rendered. No additional charges may be made to the patient for such services, except for authorized co-payment.

(b) All providers will insure:

- (1) Services are offered in accordance with Title VI of the 1964 Civil Rights Act;
- (2) Services are offered in accordance with Section 504 of the Rehabilitation Act of 1973, as amended;
- (3) All services provided maintain a high standard of quality and shall be within the reasonable limits of those which are customarily available and provided to most persons in the community with the limitations and exclusions hereinafter specified.

ELIGIBILITY
Dental services are available to all eligible Medicaid recipients, as described by 10A NCAC 21B.

AMOUNT: DURATION: AND SCOPE OF SERVICES
(a) Necessary and essential dental services, subject to the criteria and restrictions in the North Carolina Dental Manual are covered for all eligible Medicaid recipients. Only the procedures listed in the North Carolina Dental Manual are generally covered under the North Carolina Dental Program.
(b) Exceptions may be made when recommended by the Dental Consultant and approved by the agency head when:
- (1) An emergency condition causing pain or suffering needs immediate attention; or
- (2) An alternative dental treatment plan is safe, medically acceptable and less expensive but is not on the procedure list; or
- (3) The procedure is medically necessary and is of such complexity and the circumstances are so unusual that a coverage decision requires individual consideration based on the medical condition of the client, diagnosis, prognosis, and the unavailability of other alternative treatment options.

RESTRICTIONS AND PRIOR APPROVAL
(a) The Division of Medical Assistance shall have the right of prior approval for dental services except for routine and emergency services.
(b) All other dental services are subject to prior approval. Dental services categories requiring dental prior approval are as follows: Elective root canal treatment, periodontal services, orthodontic services, complex oral surgical and reconstructive procedures, complete and partial dentures, denture relines and analgesia (nitrous oxide). Each specific procedure under the American Dental Association (ADA) service category in this Paragraph will be listed in the provider dental manual and provider bulletins with the appropriate prior approval service restriction guidelines.
(c) The Division of Medical Assistance may require prior approval for any services for individual providers who have been investigated by the Division under 10A NCAC 22F or by the Attorney General's Fraud Control Unit under 42 Code of Federal Regulations 455.300, and the investigation resulted in monetary recovery of payments made by Medicaid to the provider or criminal conviction of the provider.

GUIDELINES ON SERVICES
(a) Each Medicaid recipient may receive two oral examinations by the same provider in a consecutive 12-month period.
(b) A full mouth series is allowed every five years.
(c) Dental prophylaxis or dental prophylaxis with immediate fluoride application is limited to two occasions in a consecutive 12-month period. Fluoride treatment is non-covered for patients 21 years of age and older.
(d) Replacement of complete or partial dentures may be made once every ten years. Replacement after the expiration of fewer than ten years may be made with prior approval if failure to replace the dentures will cause an extreme medical problem (e.g. severe weight loss due to compromised digestive function) or irreparable harm to oral tissues (e.g. oral sores or TMJ dysfunction).
(e) Initial reline of dentures may only be made if six months have elapsed since receipt of dentures. Subsequent relines are allowed only at five year intervals; if failure to reline in fewer than five years will cause an extreme medical problem or irreparable harm, relines may be made with prior approval.
(f) Standard procedures and materials shall be used for full and partial dentures. Only those dental materials and procedures accepted by the American Dental Association (ADA) Council on Dental Therapeutics are accepted for use in the dental care of Medicaid recipients. The specific use of these materials must follow the ADA Council on Dental Therapeutics guidelines for their use.

ANESTHESIA
The administration of local anesthesia is considered part of an operative procedure, and no additional fee shall be allowed. General anesthesia proposed by the dentist is covered where the need for such is demonstrated and the person administering the anesthesia is qualified.

ANALGESIA
The administration of analgesia is considered part of an operative procedure when need is evident for effectiveness and management.

DRUGS

Drugs, biologicals, or supplies used, administered, or provided by the dentist during an office or remote visit are considered part of the professional service, and no additional fee shall be allowed. Prescriptions may be written in the customary manner to meet the dental needs of the patient.

PRIOR APPROVAL

(a) All required prior approval shall be determined by the private contractor mentioned in 10A NCAC 22A .0101, and shall be given on the basis of medical need.

(b) Prior approval or authorization dates must be respected at all times. Failure to respect such dates may result in non-payment of claims. For non-payment in a denture case to be avoided, the date of final impression or of insertion may be used as the date of service if it falls within the patient's eligibility period and does not precede the date of authorization or of prior approval.